Clinical Audit: A Guide to Good Practice

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NHS Education

Clinical Audit:
A Guide to Good Practice

A practical guide to criterion audit and significant event analysis for general practitioners

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CONTENTS

	Introduction
Section ONE	**AUDIT METHOD**
	The Audit Cycle
	Choosing an Audit Topic
	Undertaking and Reporting an Audit Project
	Methods of Data Collection
	Peer Assessment of Completed Audit Projects
	Sampling
Section TWO	**SUGGESTED AUDIT TOPICS**
	Core Chronic Disease Audits
	Workload & Administration Audits
	Miscellaneous Audits
Section THREE	**SIGNIFICANT EVENT ANALYSIS**
	The SEA Technique
	Writing a Significant Event Analysis Report
	SEA Case Studies
	Peer Assessment of SEA
	SEA Proforma
APPENDICES	Marking Schedule (Audit)
	Assessment Schedule (SEA)
	Published Sampling Paper & Chart

Introduction

This booklet was produced in response to the many requests from health care practitioners and staff for a list of ideas for audit that can be easily applied in general practice. An extensive range of clinical and workload topics is covered and over 100 potential audits are described. A practical guide to basic audit method and the significant event analysis technique is also included. Additional guidance is provided on how to compile simple written reports on the completion of each activity. The language surrounding both approaches to quality improvement can be unnecessarily confusing and potentially off-putting. Hopefully we can shed some light by explaining the various terms used in a straightforward way whilst illustrating this with practical every day examples.

The evidence strongly suggests that small, highly focused audits often lead to a much better chance of the project being completed and meaningful change in practice being introduced. We cannot stress highly enough that keeping your audit projects short, simple and easily manageable is the key to success.

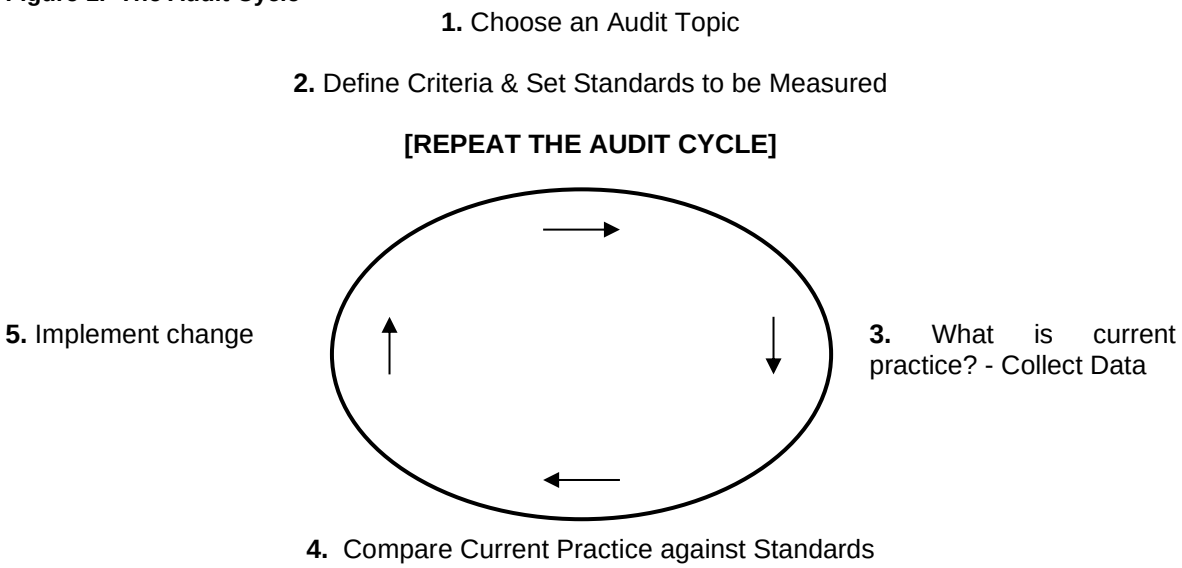
Significant event analysis (SEA) in its current form is a relatively new technique to general practice. It is potentially easier to apply than conventional audit and is increasingly encouraged as a way of learning from experience, improving health care, enhancing patient safety and potentially minimising risk in primary care. For some doctors, particularly non-principals, it may be impracticable to become involved in many of the audit topics we suggest. In this situation we strongly recommend regular participation in SEA as a temporary alternative to more conventional audit.

The provision of documented evidence of participation in audit is now a requirement for all doctors and the report formats described here will be acceptable for a variety of purposes including RCGP Practice Accreditation, West of Scotland Training Practice Accreditation, Summative Assessment, Professional Appraisal and the GMS contract.

The audit cycle

The audit cycle or loop is the traditional method we follow when carrying out an audit project (Figure 1). As the term suggests audit involves a cycle of activity, the end purpose of which is to improve the quality or effectiveness of patient care. There are a number of different stages to the audit cycle and all of them must be closely followed to enable a successful audit outcome. Failure to do so invariably leads to an audit project being left incomplete or abandoned altogether.

Figure 1. The Audit Cycle


1. Choose an Audit Topic
2. Define Criteria & Set Standards to be Measured
[REPEAT THE AUDIT CYCLE]
3. What is current practice? - Collect Data
4. Compare Current Practice against Standards
5. Implement change

Choosing an audit topic

This is a very important first step that must be given careful consideration. There should be consensus and agreement within the practice that the chosen topic for audit is a worthwhile area to study i.e. you are unsure of current practice in that area or there is agreement that this is an area where practice could be greatly improved.

Example:

If we take the example of aspirin prescribing for post-MI patients, we have an audit topic where there is a solid evidence base and which the vast majority of GPs would agree was important, worthwhile and relatively easy to undertake.

Undertaking an audit project in isolation from colleagues will potentially lead to a number of difficulties and should be avoided at all costs. For example, staff or colleagues may not be as keen to help with data collection if they feel uninvolved or suspect that the audit has

been imposed on them. Similarly you may experience difficulty or even hostility in getting others to change practice in light of your audit findings if they have not been informed or involved since the start. It is extremely important that all relevant staff are aware of what you intend to do, how you intend to do it, are agreed that it is a worthwhile exercise and are willing to support you.

Undertaking and reporting an audit project

The audit report format

In this section we outline how to write-up the findings of a new audit project (see Appendix I) - audits that are in their 3rd or 4th cycle may be concerned mainly with maintaining standards rather than the implementation of change and improving standards. This guidance is particularly important if the audit is to be peer reviewed for Appraisal or RCGP Practice Accreditation purposes. We illustrate what should happen at each stage of the audit cycle and how this should be reported by using a commonly undertaken audit topic as a practical example. The layout of the final audit report should be structured with the following headings:

1. Reason for the audit

The opening section of the report should clearly explain why the audit topic was chosen and that as a result of this choice there is the potential for change to be introduced which is relevant to the practice or you as an individual practitioner.

Choosing a topic in an area where you know the practice is strong will not lead to a completed audit cycle being achieved. For example, if the data from your initial audit findings clearly suggest that you do not have to consider the introduction of any change, or carry out a second data collection, then it is evident that this topic was not a problem area in your surgery. You should concentrate on prioritizing workload and clinical topics in areas where there is a consensus amongst colleagues that practice could most definitely be improved.

Points to consider:

- Explain why the particular audit topic was chosen. For example there may be a perceived deficiency in practice or it is an area in which it is recommended that audit should be carried out routinely and there is a perception that practice could be improved.
- Explain what potential benefits there will be to the individual undertaking the audit and/or the practice in general.

2. Criteria to be measured

Criteria and standards are often cited as the most confusing terms associated with audit. Both cause doctors and others the greatest difficulty in understanding and putting into practice. We like to think that if you can understand and differentiate between an audit 'criterion' and a 'standard' then you are well on your way to grasping basic audit method.

Criteria are simple, logical statements *used to describe a definable and measurable item of health care, which describes quality and can be used to assess it*.

Examples of audit criteria:

1. Patients with a previous myocardial infarction should be prescribed aspirin, unless contraindicated.
2. Patients with chronic asthma should be assessed at least every 12 months.
3. Patients should wait no longer than 20 minutes in the surgery before consultation.
4. The GP's medicine bag should contain a supply of in-date adrenaline.
5. Surgeries should start within 5 minutes of their allotted time
6. The blood pressure of known hypertensive patients should be <140/85

It is best to restrict the number of criteria to be measured for any given audit. Unless otherwise specified auditing a single criterion is acceptable for both Appraisal and RCGP Practice Accreditation purposes. Focusing on one or two criteria makes data collection much more manageable and the introduction of small changes to practice much less challenging. Overall it offers a better chance of the audit being completed successfully within a reasonable time span.

It is important that any criteria you choose to audit should be backed up with quoted evidence (e.g. from a clinical guideline or a review of the relevant literature). Occasionally because of the type of topic chosen, suitable evidence is not always readily available and therefore cannot be cited. If this is the case then simply explain that there is a lack of suitable evidence on the subject, but also stress that there is consensual agreement amongst your colleagues on the importance to the practice of the particular topic and criteria that have been chosen.

Points to consider:

- The criteria should be very relevant to the actual audit topic chosen.

- Follow the style (short, simple logical statements) used in the above example for each criterion, where possible.
- You must justify why each criterion is chosen, for example with reference to current literature, clinical guidelines or other evidence if available.

3. Setting Standards

An audit standard quite simply describes the *level of care* to be achieved *for any particular criterion*. It is unlikely that you will find actual percentage standards quoted in the literature or in clinical guidelines. You should arrive at the desired level of care (standard) by discussing and agreeing the appropriate figures with colleagues. There is no hard rule about standard setting – the agreed level is based on both you and your colleagues professional judgement and this will obviously vary between practices for a variety of medical and social reasons.

Examples of audit standards:

1. **90%** of patients with a previous myocardial infarction should be prescribed aspirin, unless contraindicated.
2. **80%** of patients with chronic asthma should be assessed at least every 12 months.
3. **75%** of patients should wait no longer then 20 minutes after their allotted appointment time.
4. **100%** of GPs' medicine bags should contain a supply of in-date adrenaline.
5. **95%** of surgeries should start within their allotted times.
6. **70%** of blood pressure measurements of known hypertensive patients should be <140/85

Agree on a standard, which you all believe to be an ideal or desired level of care and briefly explain why each standard was chosen (remember that different standards can be applied to each criterion). The standard(s) set should be outlined together with a time-scale as to when you expect it to be achieved (for example within 3 months if that is how long you envisage to complete the audit project). In some cases you might require to set realistic targets and a time scale towards the desired standard over a longer period of time. For example, 50% of asthmatic patients should have a management plan within 4 months, rising to 70% in 12 months, and surpassing 80% within 24 months.

Points to consider:

- Agree on and set a measurable standard for each criterion (as in the above example).
- A time scale towards achieving this standard should be included alongside.
- Briefly explain why each standard was chosen.

4. Preparation & Planning

This is an important section that is often overlooked when compiling an audit report. As previously explained audit should not be undertaken in isolation - consensus on a topic is necessary, findings should be shared and recommendations for change need to be agreed amongst the team if the audit is to have a successful outcome. Teamwork is therefore essential to audit and this must be demonstrated during the audit and evidence of this should be provided in the report. Quite simply explain in one paragraph who was involved in discussing and planning the audit, how the data were identified, collected, analyzed, and disseminated and who gave you assistance at any stage of the project (e.g. with a literature review or with collecting or analysing data) if this was required.

Points to consider:

- Describe the preparation and planning involved in undertaking the audit.
- Demonstrate evidence of teamwork in the preparation and planning of the audit.

5. Initial data collection (1)

The initial data collected should be presented using simple descriptive statistics in table format or using graphs (bar charts, pie charts etc.) Remember to quote actual numbers (n) as well as the percentage (%). Do not quote irrelevant data (for example, on age, gender, or past medical history) if it bears no relation to your chosen audit criteria.

Example of data collection (1) presentation:

Criterion	Number of MI patients (n)	Number contra-indicated	Number of patients on aspirin		**Standard (%)**
Patients with a previous MI should be prescribed aspirin, unless contraindicated	53	3	30/50	**60%**	80%

In the above example the initial audit shows that current practice is below the set standard. It is important to comment on the difference between the first collection of data (current practice in this area) and the standard previously set (the desired level of care).

Points to consider:

- Present initial data in a simple way (as above) remembering to include actual numbers as well as percentages.
- Do not present irrelevant data that is unrelated to your audit criteria.
- Always comment on how the initial data findings compared with your standard.

6. Description of change

The essence of audit is to change practice in order to improve patient care and services. This section should adequately describe any change that was discussed, agreed and introduced to practice by the team. The role of others involved in this process should also be described. An explicit example of the change that was introduced should be attached in evidence as an appendix to the report, where this is possible. Examples could include a new or amended protocol, guideline or flow chart that is introduced to practice, or a letter that is sent to a group of patients inviting them in for a review or check.

Points to consider:

- Adequately describe change to be implemented together with the role of staff involved in this and when and how it was implemented.
- Attach an explicit example/illustration to provide evidence of the change that was introduced, where this is possible

7. Data collection (2)

After change has been agreed and implemented and a reasonable period of time has elapsed to allow any new practices or systems take effect, then you must complete the audit cycle. The failure to undertake a 2nd data collection and therefore complete the audit cycle is arguably the single most common reason why many audit projects are left incomplete. As well as being a waste of time and resources, this leads to frustration for those involved as well as many missed opportunities to improve patient care.

Completion of the audit cycle is achieved by carrying out a second data collection in order to measure and evaluate what impact the newly introduced change or changes has had on improving practice in the area being audited. If no change has been introduced or it has not been given enough time to take affect then there is no point in undertaking a 2nd data collection – the findings are unlikely to show any improvement in the time that has elapsed because there has been no intervention.

Data from the second data collection should be presented in a similar way to the first round of data, but also include the results from data collection (1) alongside your desired standard as well so that comparisons can be easily made.

Example of data collection (2) presentation:

Criterion: Patients with a previous MI should be prescribed aspirin, unless contraindicated

Audit	Number of MI patients (n)	Number contra-indicated	Number of patients on aspirin		Standard (%)
Data collection (1) - March 2001	53	3	30/50	**60%**	80%
Data collection (2) - June 2001	56	3	48/53	**94%**	80%

Remember to comment on the comparison between data collections (1) and (2), and the desired standard to be achieved. If the standard is not attained or surpassed, explain why you think this is the case and how you would propose to reach it in future.

Points to consider:

- Present the findings from data collection (1) and (2), briefly compare them with each other and the standard(s) set and discuss the outcome.
- If the standard is not reached speculate as to why this was the case and how you might reach it in future.

8. Conclusions

The final section of the audit report should conclude by briefly and simply summarising what the audit achieved, and what are the main learning points gained from this exercise. In doing this, the benefits achieved through the audit should be discussed along with any problems encountered with the process or findings. Some thought should also be given as to whether the audit will be repeated in future and if so when.

Methods of audit data collection

We suggest a number of potential audit topics in this booklet, but only a small number have a suggested method of data collection outlined. We have left it up to you to decide on the best way to collect the data that is relevant to your chosen audit topic. The main reasons for this are that practices can differ in the types of information systems they have in place and how accurate and up-to-date these systems are. Similarly the paper and filing systems in operation may also differ between practices.

It is also likely that the data required for your audit project could be collected in more than one way. For example it could be easily and quickly downloaded from the information system used by the practice or it could be extracted from the patient's case records or, more likely, a combination of both. Alternatively it may have to be collected prospectively using an 'encounter sheet' to be filled in each time you meet a specific type of patient.

The main point to remember is that the data you collect should be accurate, relevant and related to the audit criteria you are measuring.

Sampling for audit – how many patients should be included?

Where it is possible try and look at all of the patients concerned with your chosen audit topic. However you may not always have the time or resources or it might be the case that the quality of your data will not be improved by studying all the cases. If this is the case you should sample from the audit population. The size of the sample should reflect the population you are studying – bear in mind the total numbers and the time span over which the audit is being carried out.

If you wish to be scientifically accurate then guidance on the number of patients that are required to be sampled from a given population when undertaking criterion-based audit is attached (see attached paper). However do remember that if you wish to submit your audit for peer assessment you are being judged on your overall understanding and application of audit method – and not your knowledge of sampling techniques or size.

Peer review of completed audit projects

Projects that have completed the audit cycle can be submitted to the west region of NHS Education for Scotland for peer review by experienced and informed GPs, in preparation for appraisal and future revalidation. Prior to submission the projects can be sent to your local Associate Adviser for formative feedback if this is required.

Submitted audits received by the department are anonymised and sent externally to two randomly chosen assessors from a group of twenty GP assessors, experienced in the assessment of completed audit projects. The audits are assessed against eight pre-agreed criteria using a validated Assessment Instrument (Appendix III.) and educational feedback on the standard of the audit is given by both peer assessors.

TOPIC (1) **Secondary Prevention of Coronary Heart Disease**

EVIDENCE SIGN Guideline No.41. Secondary Prevention of CHD following Myocardial Infarction.

CRITERIA

- Patients should have their serum cholesterol measured (fasting) between 6-12 weeks post MI.
- Patients with total cholesterol level ≥ 5.0 mmol/l should be started on lipid lowering therapy.
- Patients should be prescribed Aspirin (75-150mg/day), unless contraindicated.
- Patients should be prescribed Beta-blocker therapy, unless contraindicated.
- Patients should be prescribed ACE inhibitor therapy, unless contraindicated
- Patients should have their smoking status recorded
- Patients should have their blood pressure taken and recorded annually
- Patients blood pressure should be < 140/90

TOPIC (2) **Chronic Asthma**

EVIDENCE SIGN Guideline No. 33. Primary care management of asthma

CRITERIA

- Patients should be assessed at least once every 12 months.
- Patients should have a self-management plan.
- Patients should have had an assessment of their inhaler technique within the past 12 months.
- Patients should receive immunisation against influenza
- Patients should have their peak flow rate recorded
- Patients should have their predicted PFR recorded
- Patients should have their best PFR recorded
- Patients should have their smoking status recorded
- Patients should have their current medication recorded
- Patients on reliever medication should not be prescribed beta-blockers or NSAIDs.

TOPIC (3) **Type 2 Diabetes**

EVIDENCE UK Prospective Diabetes Study (UKPDS) Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type diabetes. Lancet

352: 837-853, 1998.

UK Prospective Diabetes Study (UKPDS) Group. Effect of Intensive blood-glucose control with metformin on complications in overweight patients with type 2 diabetes. Lancet 352: 837-853, 1998.

CRITERIA

- Patients should have their HbA1c checked every 12 months
- Patients should have their Cholesterol checked every 12 months
- Patients should have their Creatinine levels checked every 12 months
- Patients should have their urine checked for Proteinuria every 12 months
- Patients should have their Blood pressure checked every 12 months
- Patients should have their Smoking status recorded
- Patients should have their feet checked every 12 months
- Patients should have a Fundoscopy performed every 12 months
- Patients should have had their weight/BMI recorded within the past 12 months
- Patients should be given recorded advice on diet and exercise

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TOPIC (4) **Hypertension**

EVIDENCE Joint British Recommendations on Prevention of Coronary Heart Disease in Clinical Practice, British Hyperlipidaemia Association, British Hypertension Society, endorsed by the British Diabetic Association. Heart 1998 December; 80 Supp.2 S1-29.

CRITERIA

- Hypertensive patients should have an annual U&E check
- Hypertensive patients should have an annual urinalysis check for Proteinuria/Haematuria
- Hypertensive patients should have an individualised target BP level recorded in their casenotes.
- Hypertensive patients should have a BP reading at least annually

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TOPIC: **Patient Appointments**

EVIDENCE:

- Patient dissatisfaction increases from 3% with a 24-hour delay for an appointment to 71% waiting 3 days.
- It is possible to keep the delay to 3 days or less.
- Delay in getting an appointment may have clinical consequences. In one survey 40% of patients were put off trying to consult their doctor if they had to wait 3 days or more to get an appointment.
- If routine appointments are delayed requests for 'urgent' calls may increase.

CRITERION

Patients requesting a non-urgent appointment will be able to see a doctor within three working days.

METHOD & ANALYSIS

This method takes a snapshot of the appointments system at a particular time of the day.

- Data collection should be over a 4-week period (20 working days).
- Data should be collected by a nominated individual at the same time everyday during the audit period (we recommend midday or later as most same-day/held-back appointments will have been used by this time).
- The following data should be collected and entered on a data sheet:
  - Is a routine appointment available with any doctor within the next 72 hours? Yes (Y) or No (N).
- After the 4-week period is complete, the percentage availability for non-urgent appointments with any doctor should be calculated by dividing the number of days on which a non-urgent appointment was available within the next 72 hours (Y) by the total number of audit days (20) multiplied by 100. For example, if on 17 out of 20 days an appointment was available within 72 hours then we would calculate this as: 17/20 X 100 = 85%.

TOPIC: **Waiting time in the surgery**

EVIDENCE:

- Reducing waiting times is a key issue in the provision of quality services for patients and for the improvement of the working environment of doctors. In one study only 3% of patients complained about waiting up to 15 minutes.

CRITERION:

- Patients should be seen within 15 minutes of their appointment time.

METHOD & ANALYSIS

- Data collection should be over a 2-week period (10 working days).
- Data can often be collated using the Practice information system. However if you are unable to do it by this method then a paper-based system is described below:
- The following data should be collected during every surgery:
  - Name of Doctor
  - Patient's allotted appointment time
  - Patient seen within 15 minutes of appointment time? Yes (Y) or No (N)
  - Data is analysed by dividing the number patients whose appointment was within 15 minutes over the total number of patients (expressed as a percentage). For example, over a 2-week period you have a total of 200 appointments (excluding DNAs and emergencies), with 150 having been seen within 15 minutes of their appointment, then the percentage seen within 15 minutes is calculated as follows: 150/200 x 100 = 75%.

TOPIC: **Surgery start and end times**

CRITERIA:

- Surgeries should start within 5 minutes of their intended start time
- Surgeries should end within 20 minutes of the intended finish time

METHOD & ANALYSIS

- Data collection should be over a 2-week period (10 working days).
- Data should be collected either by the doctor or by another member of staff. Alternative the practice information system may be able to calculate this data.
- The following data should be collected at the start and end of every surgery:
- Did the surgery start within 5 minutes of the intended start time? Yes (Y) or No (N)
- Did the surgery finish within 20 minutes of the intended finish time? Yes (Y) or No (N)
- Data is analysed by dividing the number of surgeries starting on time (Y) by the total number of surgeries audited. For example, over a 2-week period a doctor starts 25 surgeries within 5 minutes of intended start time out of a total of 30 surgeries. Therefore the percentage compliance is 25/30 X 100 = 83% which should be compared with the standard set.

TOPIC **Referral Letters**

EVIDENCE SIGN Guideline No. 31/SCOTMEG Recommendation

CRITERIA

- Routine GP Referral letters should be sent within 3 working days.
- Routine GP Referral letters should contain adequate information e.g. on the history of the presenting complaint, reason for referral, current/recent medication and relevant clinical warnings (see guideline).

TOPIC **Patient records**

CRITERIA

- The patient's record should contain an up-to-date summary card
- Hospital letters should be filed in chronological order within the patient's record
- The patient's record should contain a contact telephone number, where available

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TOPIC **Repeat prescriptions**

CRITERIA

- Requests for repeat prescriptions should be processed within a 24-hour period (excluding weekends and public holidays)

TOPIC **Written practice reports for external agencies**

CRITERIA

- Private insurance medical reports should be typed and sent within 10 working days
- Benefits agency medical reports should be typed and sent within 5 working days.

TOPIC **Laboratory and Imaging results**

CRITERIA

- Laboratory and imaging results should be reviewed by the doctor within 3 working days of receipt.
- Laboratory and imaging results that have been reviewed by the doctor should be filed in the patient's record (where appropriate) within 5 working days

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TOPIC **Newly-registered patients**

CRITERIA

- Newly-registered patients should be offered a health check to document their past medical history and current drug therapy within 3 months of joining the practice.

TOPIC **Telephone audit**

CRITERION

- Telephone calls should be answered within 6 rings.

REASON

- The norm used in the communications industry is 6 rings, which is equivalent to approximately 16 seconds.

METHOD

- Everyone who will be involved in this audit should receive a copy of this sheet.
- The period for the audit should be agreed and made known to all staff.
- One person should be responsible for distributing the *Telephone Call Audit Forms* to receptionists and health professionals, and for collecting the completed forms.

Procedure

- A nominated member of staff should ensure at the beginning of each day that there are sufficient *Telephone Call Audit Forms* placed next to every telephone that receives incoming calls.
- Every incoming call should be dealt with as normal, but at the end of the call, two questions should be asked by the member of staff talking to the caller. In all cases, the questions should be asked by the *first person* the patient speaks to. If a call is to be referred to someone else within the practice, these two questions should be asked *before* the call is referred. The two questions are:

1. How many attempts did you have to make to get through to the surgery today?
2. How many times did the telephone ring before it was answered?

- The answers given to both questions should be numbers. Some callers may only be able to give an approximate number.
- The answers should be entered into a *Telephone Call Audit Form* as soon as possible.

TELEPHONE CALL AUDIT FORM

Ask each caller:

1. How many attempts did you have to make to get through to the surgery today? (enter the number in the **No. of Attempts** column)
2. How many times did the telephone ring before it was answered? (Circle appropriate response.)

Date:.....

No. of Attempts	No. of Rings (please circle)	No. of Attempts	No. of Rings (please circle)
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings
	0 - 6 Rings / 7+ Rings		0 - 6 Rings / 7+ Rings

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TOPIC **Chronic Obstructive Pulmonary Disease**

EVIDENCE *Immunisation Against Infection Diseases*, DoH (1996)
British Thoracic Society COPD Guidelines, Thorax, Volume 52, Supplement 5, S1-32

CRITERIA

- Patients should receive annual influenza immunisation
- Patients should have received pneumococcal vaccine
- Patient's smoking status should be recorded
- Patients on inhaled steroids should have had a 'steroid trial' prior to starting treatment

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TOPIC **Epilepsy**

EVIDENCE Diagnosis and management of epilepsy in adults – SIGN Guideline 21

CRITERIA

- Alcohol advice should be recorded in the notes
- DVLA advice should be recorded in the notes (for patients who drive)
- Seizure status in the past 12 months should be recorded in the notes

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TOPIC **Influenza Immunisation**

EVIDENCE Immunisation against infectious diseases (1996 – HMSO)

CRITERIA

- Patients with COPD should be offered immunisation
- Patients with Diabetes should be offered immunisation
- Patients with renal failure should be offered immunisation
- Patients aged 65 years and over should be offered immunisation

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TOPIC **Hormone Replacement Therapy**

EVIDENCE British National Formulary

CRITERIA

- Patients should have had a BP check in the past 12 months
- Patients should have had a breast examination in the past 12 months

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TOPIC **Annual screening of over-75s**

CRITERIA

- Patients should be offered an annual medical screening
- Patients' Next of Kin should be recorded in the case notes
- Patients' contact telephone number should be recorded in the case notes

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TOPIC **Lipid Lowering Therapy**

EVIDENCE SIGN Guideline No: 40
British National Formulary

CRITERIA

- LFT should be carried out within 3 months of starting treatment
- LFT should be recorded within the previous 12 months
- Lipid levels should be re-checked 4-6 weeks after therapy initiated

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TOPIC **Uncomplicated Urinary Tract Infection** (non-pregnant females)

EVIDENCE British National Formulary

CRITERIA

- Antibiotic courses for an acute episode should be prescribed for 3 days
- The antibiotic prescribed should be one of the 3 evidence-based recommendations

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TOPIC **Angina**

EVIDENCE SIGN Guideline No 51

CRITERIA

- Patients should be prescribed aspirin, unless contraindicated
- Patients should have had their smoking status recorded in the past 12 months
- Patients should have had their blood pressure checked in the past 12 months

- Physical activity should have been discussed and recorded in the past 12 months

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TOPIC **Rheumatoid Arthritis**

EVIDENCE SIGN Guideline No 48

CRITERIA

- Patients should have had a FBC in the past 12 months
- Patients with a history of upper GI disease should be on GI protection
- Patients on 2nd line therapy should have had appropriate monitoring (depending on drug) in the past 12 months
- Patients on 2nd line therapy should have had a hospital clinic review in the past 12 months

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TOPIC **Heart Failure**

EVIDENCE SIGN Guideline No. 35

CRITERIA

- Patients should have an Echocardiogram or radiographic evidence recorded in their notes.
- Patients should have had a medical review (either hospital or GP) within the past 12 months.
- Patients should be on an Ace Inhibitor unless contraindicated
- Patients should be on low dose beta-blockers unless contraindicated

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TOPIC **Menorrhagia**

EVIDENCE Initial Management of Menorrhagia. Royal College of Obstetricians and Gynaecologists. (1998).

CRITERIA

- Patients should have an abdominal and pelvic examination performed.
- Patients should have a full blood count obtained.
- Patients should be prescribed Tranexamic or Mefenamic acid as a first-line treatment.

TOPIC **Emergency Medical Bag**

EVIDENCE British National Formulary.
GMC Booklet – Good Medical Practice

CRITERIA

- GP's medicine bag should contain a supply of in-date aspirin.
- GP's medicine bag should contain a supply of in-date adrenaline.
- GP's medicine bag should contain a supply of in-date IV benzyl-penicillin and water solution.
- GP's medicine bag should contain a supply of in-date Glucagon

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TOPIC **Atrial Fibrillation**

EVIDENCE SIGN Guideline No. 36

CRITERIA

- Patients should be investigated by ECG and Echocardiogram.
- Patients with one or more risk factors (refer to guideline) should be considered for Warfarin therapy in place of aspirin.
- Patients should be on an anticoagulant unless contraindicated

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TOPIC **Ace Inhibitors**

EVIDENCE Adapted from North of England Evidence-Based Guideline Development Project. Evidence-based clinical practice guideline: ACE-inhibitors in the primary care management of adults with heart failure. Centre for Health Services Research, University of Newcastle-upon-Tyne.

CRITERIA

- Patients on Ace Inhibitors should have an annual review
- Patients should have a U&E check within 2-4 weeks of any dosage increase
- Patients on Ace Inhibitors for CCF should be on maximum dosage

---

TOPIC **Thyroxine**

EVIDENCE Vanderpump M P J, Alquist J A O, Franklyn J A, Clayton R A. Consensus statement of good practice and audit measures in the management of hypothyroidism and hyperthyroidism. BMJ 1996; 313: 539-543

CRITERIA

- Patients taking thyroid replacement therapy should have a thyroid function test every 12 months.
- Thyroxine (total T4) level should be maintained at between 55-144 nmol/l; TSH should be maintained at less than 6 mU/l.

TOPIC **Oral Contraceptive Pill (OCP)**

EVIDENCE Oral contraceptives and cardiovascular risk. Drug and Therapeutics Bulletin (January 2000)
Contraception by John Guillebaud, Churchhill Livingston (Publishers) 1993.

CRITERIA

- Women should have their blood pressure checked every 6 months
- Relevant risk factors (smoking, obesity, family history of CHD and focal migraine) should be recorded in the notes.
- A smear test should have been taken within the past 5 years
- Rubella immunity should have been confirmed in the past 10 years
- An in-date item-of-service claim should have been completed

---

TOPIC **H_2 Antagonists**

EVIDENCE SIGN guideline No.7

CRITERIA

- Patients over 45 years of age with dyspepsia on long term H_2 antagonists should have had an endoscopy.
- Non-steroidal anti-inflammatory drugs (NSAID) should be avoided.
- Patients should have their smoking status recorded
- Patients should have their alcohol status recorded

TOPIC **Helicobacter Pylori Eradication**

EVIDENCE SIGN guideline No.7

CRITERIA

- Patients with confirmed duodenal ulcer should receive *H.pylori* eradication therapy.
- Patients with benign gastric ulcer should have their *h.pylori* status checked before eradication therapy is prescribed.

TOPIC **Risk Management – Patients 16 years and over**

CRITERIA

- Patients aged 16 years and over should have their smoking status recorded in their notes.
- Patients aged 16 years and over should have their alcohol status recorded.
- The contact details of patients aged 16 years and over should be up-to-date
- The Next of Kin details of patients aged 16 years and over should be up-to-date

---

TOPIC **Leg Ulcer**

EVIDENCE SIGN guideline No. 26

CRITERIA

- Patients should have ankle brachial pressure ratio (ABPI) measured by hand-held Doppler.
- Patients should have a comprehensive reassessment 12 weeks after diagnosis and every 12 weeks thereafter.
- Patients should have a blood glucose measurement
- Patients with venous leg ulceration should receive graduated compression therapy

---

TOPIC **Intermittent Claudication**

EVIDENCE SIGN guideline No. 27

CRITERIA

- Patients should be prescribed appropriate drug therapy including aspirin.
- Patients should have their smoking status recorded
- Patients should have had a random blood glucose check within the last 3 years
- Patients should have had their lipids checked within the last 3 years

---

TOPIC **Warfarin Monitoring**

EVIDENCE British National Formulary
SIGN Guideline No. 36

CRITERIA

- Patients should have the indication for Warfarin recorded
- Patients should have the anticipated duration of therapy recorded.

- Patients should have their INR checked at 4-8 week intervals (where the practice is responsible for monitoring).

TOPIC **Lithium Monitoring**

EVIDENCE British National Formulary.
SIGN Guideline No. 36
Drugs and Therapeutics Bulletin Vol. 37. March 1999.

CRITERIA

- Patients receiving Lithium treatment must be recorded in a practice Lithium Register.
- Patients should have their Lithium levels checked every 3 months (where the practice is responsible for monitoring).
- Patients should have their renal function checked in the last 12 months.
- Patients should have their thyroid function checked in the past 12 months.
- Patients should have a calcium check in the past 12 months

TOPIC **Depo-Provera**

EVIDENCE Depo-Provera and bone density (Review No. 2002/01). Faculty of Family Planning and Reproductive Health Care (RCOG)

CRITERIA

- Patients requesting Depo-Provera should be informed (recorded in notes) of the association of long-term use with loss of bone mass
- Patients with a 2-year history of amenorrhoea should be considered for a Dexa scan
- Patients should not be on Depo-Provera for more than 5 years

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TOPIC **Osteoporosis**

EVIDENCE National Osteoporosis Society – Accidents, Falls, Fracture, and Osteoporosis; A strategy for Primary Care Groups and Local Health Groups (January 2000)
National Service Framework for Older People (HMSO, 2001)

CRITERIA

- Women (aged 44-55) who have consulted in the past 12 months should have the following recorded in their notes: menopausal status and discussion of HRT.
- The records show that women aged 65 years and over and/or resident in residential/nursing homes should have been considered for vitamin D and calcium supplementation.
- Patients ‘at high risk’ of developing osteoporosis should have had their bone densitometry

checked [high risk factors: long term steroid users; early menopause (before 45 years); minimal trauma fracture; low body mass index (<21); strong family history of osteoporosis; elderly women in long stay institutions; and chronic disabled (rheumatoid arthritis, multiple sclerosis)]

TOPIC **Schizophrenia**

EVIDENCE Clinical Standards Board for Scotland (Clinical Standards for Schizophrenia)

CRITERIA

- Patients should have anti-psychotic medication reviewed regularly (in the past 6 months)
- Compliance with anti-psychotic medication should be recorded
- Patients should have their use of alcohol documented
- Patients should have their use of illicit drugs documented

TOPIC **Detection of Hypertension**

EVIDENCE Joint British Recommendations on Prevention of Coronary Heart Disease in Clinical Practice, British Hyperlipidaemia Association, British Hypertension Society, endorsed by the British Diabetic Association. Heart 1998 December; 80 Supp.2 S1-29.

CRITERIA

- Patients aged 40 years and over should have had a blood pressure check carried out at least once in the last 5 years.

TOPIC **MMR Vaccination**

EVIDENCE Immunisation against infectious diseases (HMSO, 1996)

CRITERIA

- Children in age group 13-24 months should be offered MMR
- Children in age group 48-60 months should be offered vaccination

---

TOPIC **Benzodiazepines**

EVIDENCE British National Formulary

CRITERIA

- Patients on long-term Benzodiazepines must be recorded on a specific register or a computerised repeat prescribing system

- The records of long-term users show that they have been assessed on their suitability for withdrawal.

- The records show that the patient has been advised on the potential for dependency

---

TOPIC **Smoking cessation**

EVIDENCE Ashenden R, Silaggy C and Weller D (1997). A systematic review of the effectiveness of promoting lifestyle change in general practice. Family Practice 14: 160-176.

CRITERIA

- The records of known smokers who have consulted in the past 12 months should show the daily number of cigarettes smoked

- The records of known smokers who have consulted in the past 12 months should show that their motivation to stop smoking has been ascertained

- The records show that patients who are motivated to stop have had the use of NRT discussed

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TOPIC **Depression**

EVIDENCE Donohughe JM and Tyler A (1996). The treatment of depression: prescribing patterns of anti-depressants in primary care in the UK. Br J Psychiatry 168: 164-168.

CRITERIA

- The records of known patients suffering from depression should show that they have been assessed for the risk of suicide

- Anti-depressants should be prescribed in therapeutic doses

- After commencement of treatment the patient should be reviewed within 3 weeks

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Introduction

The use of significant event analysis (SEA) is strongly encouraged in primary care as a structured way of learning, improving patient care and safety, and minimising risk. Pringle and colleagues studied the feasibility and potential of SEA in the mid-1990s and concluded that it was a valuable technique for individual case review, which should be applied alongside conventional audit. Evidence of participation in SEA is now a requirement of RCGP Practice Accreditation, the west of Scotland GP training practice environment, the GMS contract and as part of GP Appraisal. It is likely also to be a future requirement of medical revalidation for all general practitioners.

In comparison with conventional audit, SEA can sometimes seem the more attractive option. It can involve less preparation and paperwork and often has the potential to introduce change much quicker. On the downside it can be superficial if not tackled properly. However, SEA should not be looked upon as a replacement for clinical audit, but rather as being complementary to it.

<u>The SEA technique</u>

SEA involves reviewing individual case studies or events that have happened in the practice. It is mainly a team-based activity where the emphasis is on learning from events and changing practice as a way of minimising the chances of them recurring in future. SEA is a non-threatening technique that encompasses a 'no blame' approach, where we look at **what** is wrong and not **who** is wrong.

<u>What is a significant event?</u>

"Any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice". (Pringle *et al*, 1994)

The definition of a significant event outlined here is a very broad based one. It should be noted that significant events do not have to be 'critical' or 'adverse', but can also 'celebrate' the confirmation of good practice. In reality, however, most significant events, whether clinical or administrative, can be broadly categorised as adverse occurrences, near misses or errors.

<u>Selection of significant event topics</u>

The selection of significant event topics is very important as the wrong selection can potentially lead to conflict, bad feeling and low morale – so care must be taken when

considering certain events for discussion.

SEA topics that should not be up for discussion include those where individuals or groups of staff have an obvious hidden agenda. Other topics that are inappropriate for SEA include those where individual poor performance (e.g. lateness, slackness, work difficulties) has been identified. SEA is not the forum for this, nor is it the forum for personal matters (e.g. personal hygiene, dress code), confidential matters (staff health) or contractual matters (pay, working-hours etc.). Individuals in attendance should have the right to take items off the agenda that they find too intimidating or sensitive.

What is a significant event **analysis**?

Simply acknowledging and discussing a significant event amongst colleagues after it happens is not enough – it is likely to recur if that is all that is done. SEA allows for a structured analysis so that a clear picture of what happened is established, insight into the event is demonstrated, change is speedily introduced (if appropriate) and lessons are learned. The chances of it are happening again are hopefully minimised.

When undertaking a significant event analysis we should ask ourselves four questions (see Appendix II):

1. What happened?
2. Why did it happen?
3. What have I learned?
4. What have I changed?

What Happened?

In this section of the report all of the facts relating to the identified significant event should be described so that those reading the report (including potential peer or RCGP assessors) can get a clear picture of the details of the event its impact or potential impact on the patient or the conduct of the practice. The significant event being described should be studied because it deals with a quality of care or patient safety issue, or has personal impact on staff, or has an effect on the practice as a whole.

Why did it happen?

In this section the author should give clear reasons why the event occurred. This allows the reader to identify what areas of the practice or system are being investigated and

focuses your own thoughts on specific areas that may need to be addressed.

What have you learned?

An explanation should be given of any learning experience you have had: for example it may be related to learning issues concerned with therapeutics, disease management or administrative procedures. However it could also reflect a learning experience in dealing with patients, colleagues, staff, or other organisations.

What have you changed?

With most significant events, a change in some aspect of care is required to improve the quality of care and/or minimise the risk that a similar event will occur. If this is the case then a description of the change actually implemented should be given rather than a "wish list" of thoughts, which may potentially minimise risk but have not yet been carried out.

On occasions it may not be possible to implement change either because the likelihood of the event happening again is so rare or because change is outwith the control of the individual or the organisation. If this is the case then the reasons behind this should be clearly documented.

Finally, significant events need not necessarily be adverse events or near misses, but can reflect high quality care. In this case the reason for not changing any aspect of care can be easily documented, as it is obviously not required.

Peer review of significant event analyses

SEA reports can be submitted in a standard format to the west region of NHS Education for Scotland for peer review feedback.

Submitted SEA received by the department are anonymised and sent externally to two randomly chosen assessors from a group of twenty GP assessors, experienced in the assessment of SEA. The SEA is assessed against four pre-agreed criteria using an assessment schedule (Appendix IV) – all four are required to be present for a satisfactory analysis as judged by two independent assessors. Written educational feedback is given to GPs whose SEA is considered unsatisfactory by one or both of the assessors.

GUIDANCE

SEVEN STEPS to a Significant Event Analysis:

STEP ONE

Identify and prioritise a significant event for analysis. However, it would be impracticable to analyse every event so these should be prioritised in terms of importance to patient care and safety.

STEP TWO

*Collect and collate as much **factual information**, including written records, on the event as possible. Also gather the thoughts, opinions and impressions of those directly and indirectly involved including, where relevant, patients/relatives or health professionals from outwith the immediate team*

STEP THREE

*Convene a **meeting to discuss** and analyse the significant event that involves all relevant members of the team. The meeting should be conducted in an open, fair, honest and non-threatening atmosphere. A minute of the meeting should be taken and circulated.*

STEP FOUR

*Undertake an **analysis of the significant event** by answering the four questions outlined previouslyf. Remember that the analysis should be structured, investigative and in-depth rather than being simply discursive and superficial. The evidence indicates that this type of informal, unstructured approach may lead to a poorer event analysis. An individual should be appointed to manage the change process. . Not every event analysis requires action to be taken. However change should still be considered and justifiably ruled out if not required in this instance.*

STEP FIVE

Monitor any changes agreed and implemented.

Change progress should be monitored at future team/significant event meetings.

STEP SIX

***Write it up -** Keep a written record of every event analysis undertaken using the method outlined overleaf. Remember that SEA is a retrospective technique. Any change or action described in a completed event analysis report should already have happened or be in progress rather than simply being suggested.*

STEP SEVEN

*External comment – It is good practice to get outside feedback on the standard of an event analysis that is undertaken. **Peer review** is one method of doing this and is recommended where this type of educational model exists.*

Further information:

www.nes.scot.nhs.uk
www.bmjlearning.com
www.saferhealthcare.org.uk

Further reading

BOWIE P, COOKE S, LO P, McKAY J, LOUGH M
The assessment of criterion audit cycles by external peer review: when is an audit not an audit?
Journal of Evaluation in Clinical Practice (In Press)

BOWIE P, McKAY J, DALGETTY E, LOUGH M.
A qualitative study of why general practitioners may participate in significant event analysis and educational peer review.
Quality & Safety in Health Care 2005; 14: 185-189

McKAY, J, BOWIE P, LOUGH M.
Variations in the ability of general medical practitioners in applying two methods of clinical audit: a five-year study of assessment by peer review.
Journal of Evaluation in Clinical Practice (In Press)

BOWIE P, McKAY J, NORRIE J, LOUGH M
Awareness and analysis of a significant event by general practitioners: a cross-sectional study.
Quality & Safety in Health Care 2004; **13**: 102-107

BOWIE P, McKAY J, LOUGH M
Peer assessment of significant event analyses: being a trainer confers an advantage.
Education for Primary Care 2003 **14**(3): 338-344

McKAY J, BOWIE P, MURRAY L, LOUGH M
Attitudes to the identification and reporting of significant events in general practice.
Clinical Governance: An International Journal 2004 **9** (2) 96-100

McKAY J, BOWIE P, MURRAY L, LOUGH M
Barriers to significant event analysis: An attitudinal survey of principals in general practice. *Quality in Primary Care* 2003; **11**: 189-98

McKAY J, BOWIE P, LOUGH M
Evaluating significant event analyses: implementing change is a measure of success.
Education for Primary Care 2003; **14**(1): 34-38

BOWIE P, McKAY J.
Seven steps to analyzing a significant event: a simple, non-threatening approach for primary care.
BMJLearning.com

BRADLEY C. P.
Turning anecdotes into data-the critical incident technique. *Family Practice* 1992 9(1), 98-103.

PRINGLE M, BRADLEY. Significant event auditing: a users' guide. *Audit Trends* 1994 2, 70-73.

PRINGLE M, BRADLEY C. P, CARMICHAEL, C. M. ET AL. *Significant event auditing. A study of the feasibility and potential of case-based auditing in primary medical care*.
1994 Occasional Paper 70 Royal College of General Practitioners.

SWEENEY G, WESTCOTT R, STEAD J.
The benefits of significant event audit in primary care: a case study.
Journal of Clinical Governance 2000; 8:128-134.

SIGNIFICANT EVENT ANALYSIS (CASE STUDY 1)

What happened?

A patient arrived at the reception desk to pick up a prescription for Amitriptyline. He was given the prescription for Amitriptyline dated the previous day, but in addition there was also a prescription for Amitriptyline which had been lying from the month before and he was also given this prescription. The patient therefore had a large amount of Amitriptyline at home and over the following few days an overdose was taken, with hospital admission and monitoring required.

Why did it happen?

Issues that could be discussed here include the:

- system to identify prescriptions which have not been collected?
- system to minimise quantity of potentially dangerous drugs available to patient?
- follow up of patients with significant illness using potentially dangerous drugs?
- GP practice prescribing for patient normally reviewed in secondary care?

What would you change?

Potential solutions:

- Named person to remove prescriptions from prescription box after x days if not collected
- Prescription then to be destroyed or prescriber notified
- Repeat prescriptions for potentially dangerous drugs to be “tagged” so that when a new prescription is generated a check can be made that previous prescription has been uplifted.
- Prescription may be marked weekly dispense to minimise volume available
- Possible increased review of patients on particular medications to assess risk
- Discussion with pharmacist, if patient uses the same pharmacy to “flag up “ issues over frequency of dispensing.

What are the main learning points?

- There is no foolproof system to stop this patient hoarding medication and subsequently overdosing, however risk can be reduced.
- Change needs to be implemented to put in place a system which regularly checks for “old” prescriptions and allows action, if necessary, to be taken.

SIGNIFICANT EVENT ANALYSIS (CASE STUDY 2)

What happened?

A patient complained about the practice vaccination policy. Part of the complaint was that she and her husband had attended the practice nurse on separate occasions for holiday vaccination. One patient had blood drawn off to check for Hepatitis A titres prior to immunisation whilst the other patient did not have any check for titres but was given immunisation straight away. There was no age difference in the patients.

Why did it happen?

- Nurse education – Unsure which patients may be offered a blood test to check for previous Hepatitis A exposure and thus avoid need for vaccination
- No clear policy/protocol for the nurse to follow.

What would you change?

- Develop a protocol for nurses and doctors to follow so that advice given to patients is consistent.
- When constructing protocol obtain evidence from published literature and local specialist

What are the main learning points?

A situation existed where there was uncertainty amongst the nursing staff and doctors both individually and collectively as to immunisation practice. This led to inconsistent care. Developing clear guidelines would improve both knowledge and procedure

SIGNIFICANT EVENT ANALYSIS (CASE STUDY 3)

What happened?

A patient was referred to a rheumatologist because of arthritic symptoms. The rheumatologist diagnosed rheumatoid arthritis and asked for the patient to be commenced on sulphasalazine. The patient was given a prescription for 1-month supply of the drug and told that it would be put on repeat prescription. The patient phoned in to obtain a repeat prescription 3 months in a row, but the repeat prescription has been entered as sulphadiazine instead of sulphasalazine. He therefore had 3 months of sulphadiazine in error prior to the mistake being identified.

Why did it happen?

Issues raised:

- No method of ensuring that correct drug had been entered on the computer.
- Current system relied on computer operator entering drug correctly
- No patient follow-up for 3 months by doctor. If reviewed earlier this error would have been spotted.
- Unusual drug/quantity – why did pharmacist not contact GP?

What would you change?

Implement a system to ensure that the doctor who asks for the drug to be put on repeat prescription checks that the correct drug has been entered onto the computer system e.g. by checking the entry after the computer operator prints out the drug summary sheet.

What are the main learning points?

- It is not possible to assume that entries processed onto computer are always correct.
- Equally we cannot assume that patients or pharmacists, will necessarily spot errors “down the line.”
- A system is therefore required to ensure correct processing of information.

SIGNIFICANT EVENT ANALYSIS (CASE STUDY 4)

What happened?

A child was in the routine immunisation clinic. The nurse assumed that he was there for all the injections and administered DTP booster along with the MMR. It was only on questioning by the mother as she was leaving regarding side effects that she discovered the child had had the MMR, which she did not want her child to have.

Why did it happen?

The practice did not have a system in place which made clear to parents what vaccinations were being proposed, and the system did not allow for the nurse to check with the parents that they were aware of what vaccines their children were being given

What would you change?

The practice system could be changed so that information leaflets are given to parents regarding the proposed vaccinations prior to the actual appointment. As a minimum the parent should be told what vaccinations their child is due to receive The nurse/ doctor or health visitor giving the injection should make it clear to the parent what vaccinations they are proposing to give prior to asking for the consent form to be signed.

What are the main learning points from this?

Do not assume that patients/relatives are aware of which vaccinations are being given. A clear explanation for the purpose of the injection should always be given.

APPENDIX i

Sample Report Form: AUDIT

Title of project:

***** Audit reports tend to range in length from a few to a dozen pages, depending on the size of the audit.

1. Reason for the audit

2. Criterion or criteria to be measured

3. Standard(s) set

4. Preparation and planning

5. Results of data collection ONE

6. Description of change(s) implemented

7. Results of data collection TWO

8. Conclusions

APPENDIX ii

Sample Report Form: Significant Event Analysis

Date of significant event:

Date of significant event meeting:

Date report compiled:

What happened?

(Describe what actually happened in detail. Consider, for instance, how it happened, where it happened, who was involved and what the impact or potential impact was on the patient, the team, organisation and/or others).

Why did it happen?

(Describe the main and underlying reasons – both positive and negative – contributing to why the event happened. Consider, for instance, the professionalism of the team, the lack of a system or a failing in a system, lack of knowledge or the complexity and uncertainty associated with the event).

What have you learned?

(Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education & training; the need to follow systems or procedures; the vital importance of team working or effective communication).

What have you changed?

(Outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a letter of apology to a patient or a new protocol).

PEER REVIEW FEEDBACK INSTRUMENT

SIGNIFICANT EVENT ANALYSIS REPORT

Project Number

Project Title

INSTRUCTIONS FOR PEER REVIEWERS

Please use the attached tool to critically review and rate each relevant area of the SEA report. Feedback on how to improve the event analysis should be constructive and given in the comments section at the end of each relevant area. Similarly, where an area of the analysis has been undertaken well please comment on this so it too can be given as positive feedback to the submitting GP. Please remember that all educational feedback should be specific, informative, sensitive and directed towards improving the event analysis

Please rate the level of evidence contained in the audit report for each of the criteria listed overleaf (using the rating scale where 1=Very Poor and 7=Outstanding):

Project Reviewer…….

What happened?

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
1. The description of what actually happened:	☐	☐	☐	☐	☐	☐	☐
Comments:							
2. The role(s) of all individual(s) involved in the events has been described:	☐	☐	☐	☐	☐	☐	☐
Comments:							
3. The setting(s) where the event happened has been described:	☐	☐	☐	☐	☐	☐	☐
Comments:							

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding	Not appropriate
4. The impact or potential impact of the event has been described:	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								

Why did it happen?

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
5. The underlying reason(s) why the event happened has been described:	☐	☐	☐	☐	☐	☐	☐
Comments:							

Reflection and Learning

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
6. Reflection on the event has been demonstrated:	☐	☐	☐	☐	☐	☐	☐
Comments:							

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
7. Where possible, appropriate individual(s) have been involved in the analysis of the significant event:	☐	☐	☐	☐	☐	☐	☐

Comments:

8. Learning from the event has been demonstrated:	☐	☐	☐	☐	☐	☐	☐

Comments:

Appropriate Action Taken

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding	Not appropriate
9. Appropriate action has been taken (where relevant or feasible):	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

Please add any general comments

Global Rating Scale

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
10. Please rate the overall analysis of the significant event	☐	☐	☐	☐	☐	☐	☐

Validation Judgement

For those doctors who wish feedback on whether their project is satisfactory or unsatisfactory, please indicate your judgement below.

☐ Satisfactory ☐ Unsatisfactory

PEER REVIEW & FEEDBACK INSTRUMENT

Criterion Audit

Reason for the Choice of Audit

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
1. The potential for change is described:	☐	☐	☐	☐	☐	☐	☐
2. The project is relevant to practice	☐	☐	☐	☐	☐	☐	☐

Comments:

Criterion or Criteria Chosen

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
3. Are relevant to the audit subject and justifiable e.g. current literature:	☐	☐	☐	☐	☐	☐	☐

Comments:

Standards Set

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
4. A standard(s) is/are set with a suitable timescale	☐	☐	☐	☐	☐	☐	☐

Comments:

Preparation and Planning

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
5. There is evidence of teamwork and adequate discussion where appropriate	☐	☐	☐	☐	☐	☐	☐

Comments:

Data Collection (1)

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
6. Results are compared against standard(s) set	☐	☐	☐	☐	☐	☐	☐

Comments:

Changes to be evaluated

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
7. An actual example of change(s) described	☐	☐	☐	☐	☐	☐	☐

Comments:

Data Collection (2)

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
8. There is comparison with the first data collection and standard(s)	☐	☐	☐	☐	☐	☐	☐

Comments:

Project Conclusions

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
9. There is a summary of the main issues learned	☐	☐	☐	☐	☐	☐	☐

Comments:

Global Assessment of Criterion Audit

	1. Very Poor	2. Poor	3. Fair	4. Good	5. Very Good	6. Excellent	7. Outstanding
10. Please rate the audit project(s) overall	☐	☐	☐	☐	☐	☐	☐

Comments:

Validation Judgement

For those doctors who wish feedback on whether their project is satisfactory or unsatisfactory, please indicate your judgement below.

☐ Satisfactory ☐ Unsatisfactory